DRAFT

The Montana Patient-Centered Medical Home Program

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The PCMH Concept

- Not a building, house or hospital
  - Team of professionals focused on keeping you healthy
  - All of a patient's primary care in one place
- Patients are a proactive part of the team
  - Engaged in their health care plan and steps toward better health
- Care is personalized to a patient's needs
  - A behavioral health consultant for tobacco cessation, a nutritionist for diabetes, and a care coordinator to explain lab results are just a few examples of members of a diverse care team

The PCMH Concept

- Whole Person Care
  - Patients aren't solely treated for the one ailment that caused them to visit on a particular day
  - All health factors are considered and treatment of each is coordinated – i.e. correlations between proneness to depression AND difficulty managing diabetes
- Care is integrated and coordinated
  - PCMHs coordinate care with other parts of the health care system such as specialty doctors, hospitals and nursing homes
  - Patients are connected to community resources such as affordable housing or insurance

PCMH Definitions

- The National Committee on Quality Assurance (NCQA) defines PCMH as:
  - The patient-centered medical home is a way of organizing primary care that emphasizes care coordination and communication to transform primary care into "what patients want it to be." Medical homes can lead to higher quality and lower costs, and can improve patients' and providers' experience of care.

- PCMH definition in Montana law:
  - model of health care that is:
    (a) directed by a primary care provider offering family-centered, culturally effective care that is coordinated, comprehensive, continuous, and, whenever possible, located in the patient's community and integrated across systems;
    (b) characterized by enhanced access, with an emphasis on prevention, improved health outcomes, and satisfaction;
    (c) qualified by the commissioner under 33-40-104 as meeting the standards of a patient-centered medical home; and
    (d) reimbursed under a payment system that recognizes the value of services that meet the standards of the patient-centered medical home program

The Montana PCMH Act

Became Law on April 30, 2013:

- Codified the definition of PCMH in Montana state law
- Gave the insurance commissioner rule making authority to govern the program, such as
  - Set standards for qualification of PCMHs
  - Set standards for healthcare quality and performance measures including prevention
  - Set uniform standards for measuring cost and medical usage
- Allows the commissioner to recognize patient-centered medical homes that meet standards decided by the commissioner
- An independent study of the Montana PCMH Program's effectiveness was assigned to a legislative interim committee

Program Structure

- Approved national accrediting agencies for the Montana PCMH Program:
  - The National Committee for Quality Assurance (NCQA)
  - The Accreditation Agency for Ambulatory Health Care (AAAHC)
  - The Joint Commission
- 61 Qualified PCMHs
- 7 Provisionally Qualified PCMH
- Montana PCMH Payors :
  - Blue Cross Blue Shield of Montana
  - PacificSource Health Plans
  - Allegiance Life and Health
  - Medicaid

Program Benefits

- PCMHs can market and promote themselves as a PCMH with qualification from the Commissioner
- PCMHs can engage in enhanced payment contracts with Montana PCMH payors
- Data feedback, resources, and technical assistance available

PCMH Payor Programs

- Blue Cross Blue Shield of Montana
  - PMPM preventive and chronic disease management payments
  - Quality bonus incentives
- Allegiance Life and Health
  - Comprehensive Care Coordination billing code
- Montana Medicaid
  - PMPM preventive and chronic disease management payments
- PacificSource Health Plans
  - PCP and chronic illness reports

Clinic Eligibility

- The Montana PCMH Program is only for **primary care practices** in our state that meet the following criteria:
  - 75% of patients use their personal primary care provider for :
    - First contact of care
    - Continuous care
    - And comprehensive primary care services

NCQA

NCQA

Applying to the Program

Provisional Status

- Working toward recognition/accreditation from a nationally recognized entity such as NCQA
- On track to receive recognition within 12months
- Subject to the same application and reporting requirements
- Reap the same benefits as qualified clinics

Qualified Status

- Already received recognition from a nationally recognized entity such as NCQA
- Must submit verification of the recognition with their Preliminary Application

Applying to the Program

- Preliminary Application
  - Simple 1 page form
  - Clinic contact information
  - Name of accrediting entity
  - Date clinic received PCMH recognition from entity OR
  - Date clinic is working toward receiving recognition (Provisional Qualification)

Applying to the Program

- Comprehensive Application
  - 40 question online survey
  - All check the box/multiple choice questions
  - Identifies clinics' transformations focuses, strengths, and weaknesses
  - Informs program administrators of clinic's situation technologically and culturally to help connect peer mentors, consultant TA, and other resources
  - Provides details on program composition such as team members, patient population sizes, and IT resources to inform the council and other policymakers and helps clinics use information to leverage resources with their organization's administrators.

Progress Update & Annual Report

- Progress Update
  - Brief follow-up on a subsection of questions from the Comprehensive Application
  - To be completed every October or 1 year from application date
  - Tracks transformation progress and clinic composition changes

- Annual Report
  - 10 Narrative response questions
  - Clinics only have to respond to those applicable
  - Provides qualitative information/anecdotal evidence about the important PCMH work clinics are doing

Clinical Quality Reporting Standards

- As required by administrative rule, all PCMHs submitted 2015 and 2016 data on three of four quality metrics:
  - Hypertension blood pressure control
  - Tobacco use and intervention
  - Diabetes A1C control
  - and childhood immunizations
  - Depression screening (added for 2016)
- Specifications aligned with Physician Quality Reporting System (PQRS) and the National Immunization Survey (NIS)
- Produce meaningful data that is not burdensome because metrics are related to high-cost, chronic diseases and already reported to other entities
- Track how PCMHs improve the care and health of their patients through both preventive care and chronic disease management

Clinical Quality Reporting Standards

Clinics had 2 choices for the 2015 and 2016 reports:

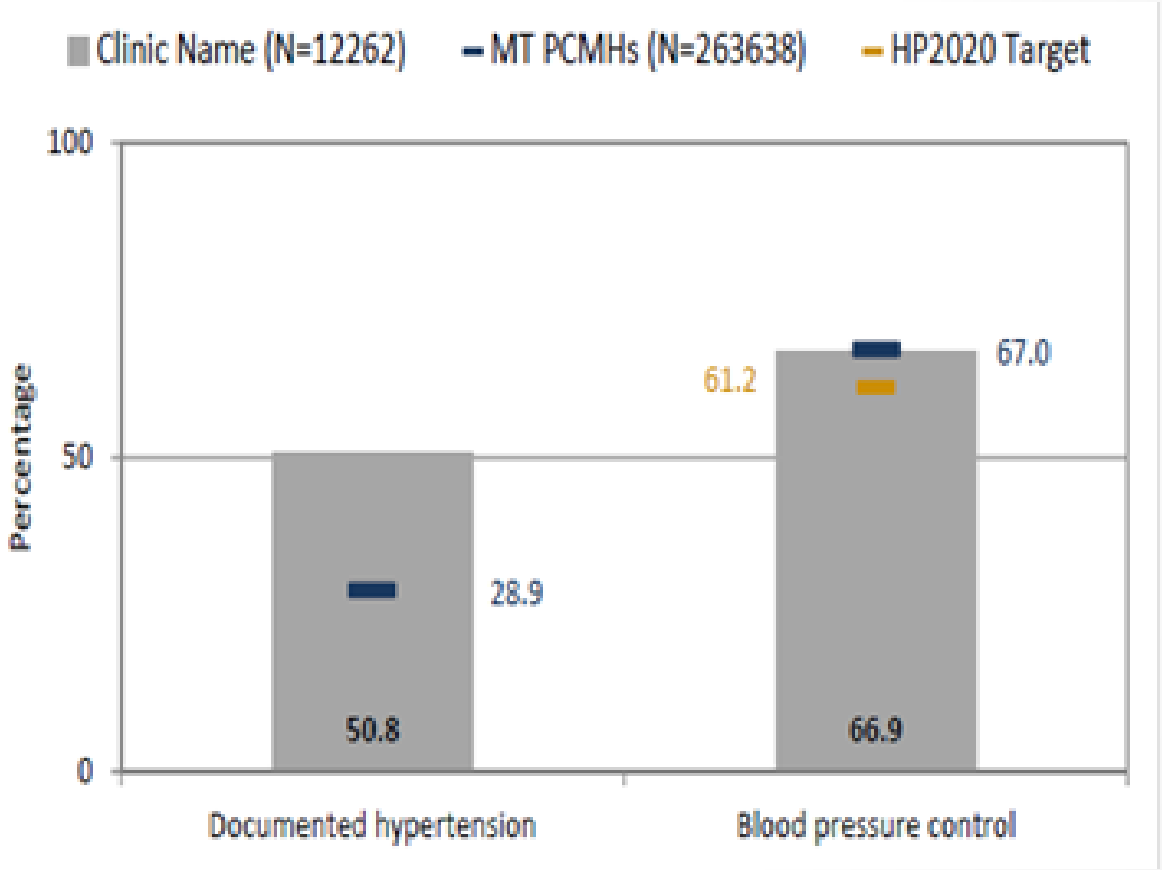
- Patient-level data including the age and sex of each patient (unidentified) with the diagnosis pertaining to each measure, and the date of their measurement
- OR attested aggregate rates for each measure (Numerator and Denominator)

Research and consultation with PCMH experts has shown patient-level data is critical to accurate and meaningful PCMH evaluation

Stakeholders voted that by the 2017 report on data from 2016, all PCMHs MUST report patient-level data on four out of five measures.

DPHHS Hypertension Data Analysis

Percentage of adult patients (18–85 years) with documented hypertension and of those who had blood pressure controlled (systolic <140 mm Hg and diastolic <90 mm Hg), at most recent outpatient visit.



Clinic Name — 2014

Blood Pressure

Figure 1. Percentage of adult patients aged 18–85 years with documented hypertension* and of those who had blood pressure controlled (systolic <140 mmHg and diastolic <90 mmHg) at most recent outpatient visit.

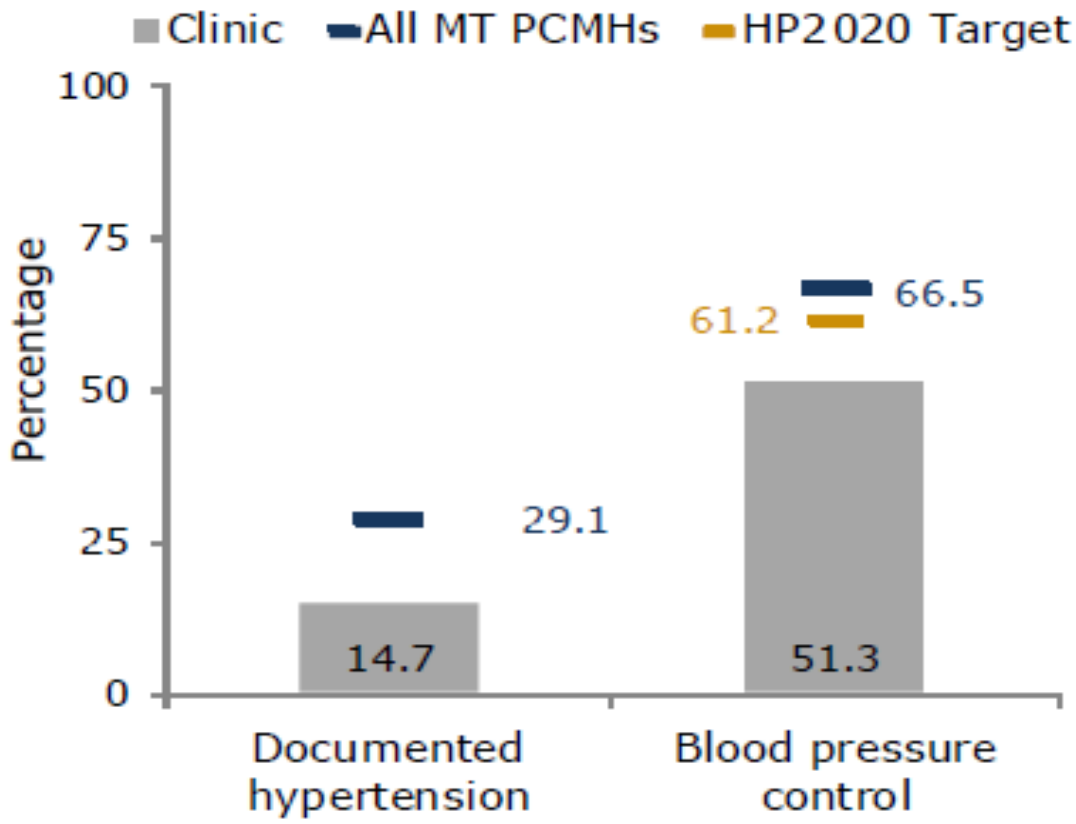


Figure 2. Percentage of adult patients aged 18–85 years with documented hypertension* who had their blood pressure controlled (systolic <140 mmHg and diastolic <90 mmHg) at most recent outpatient visit, **by sex.**

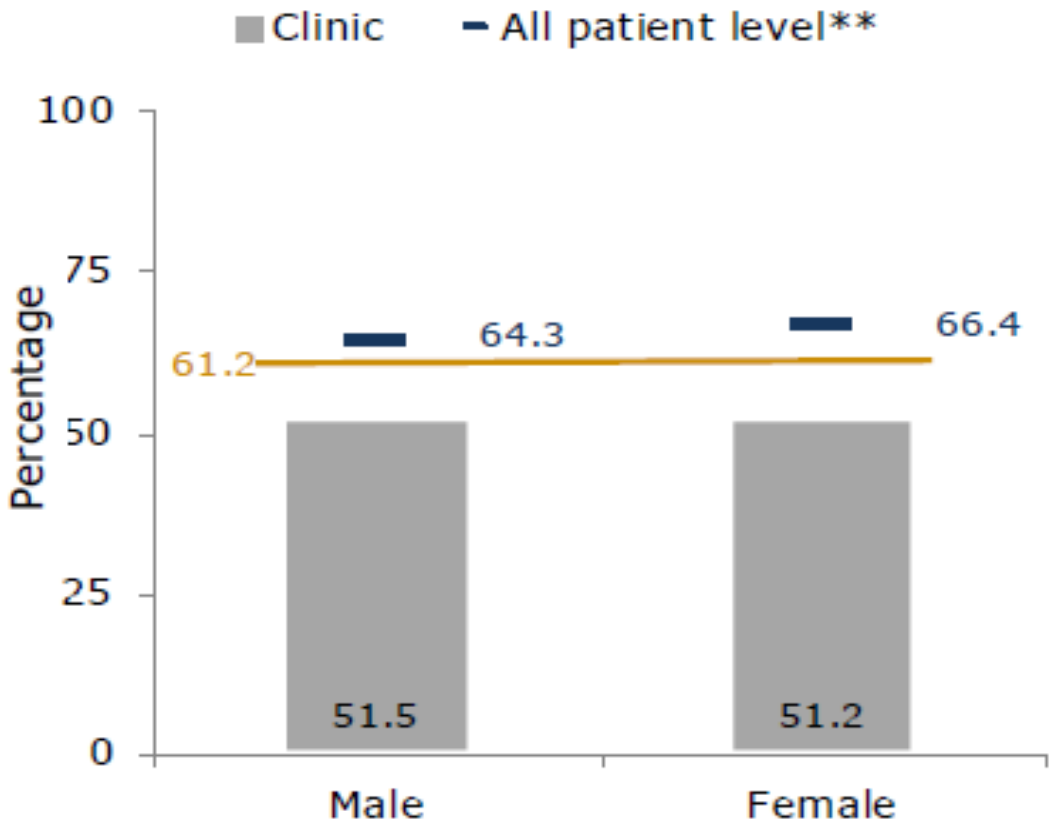
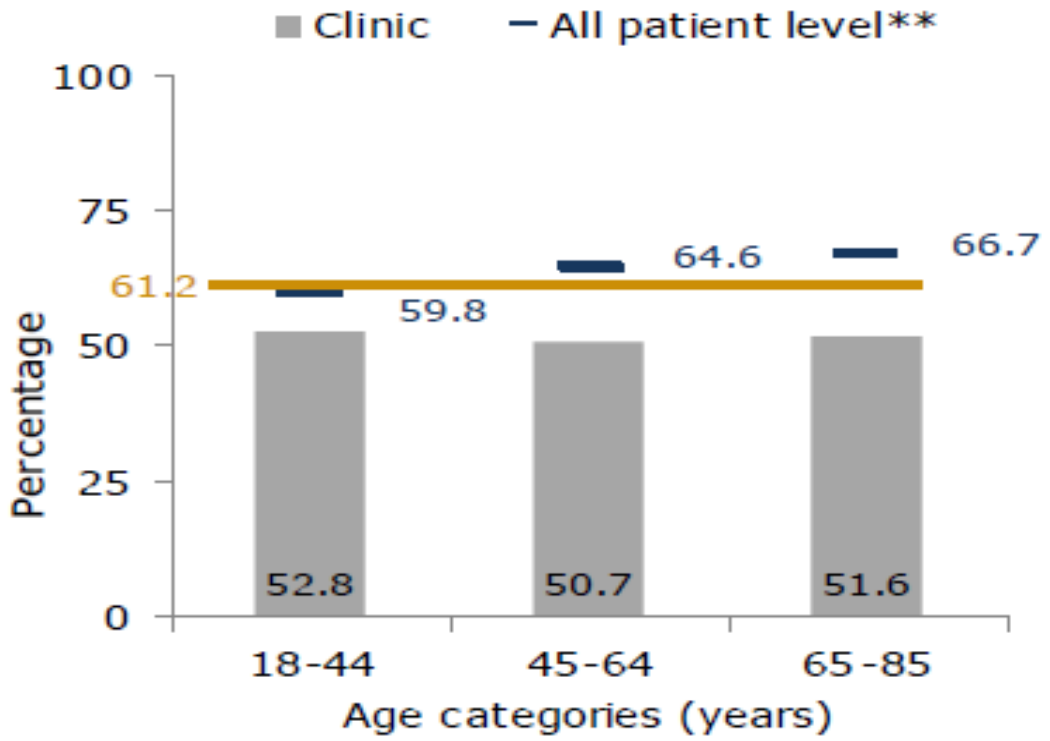


Figure 3. Percentage of adult patients aged 18–85 years with documented hypertension* who had blood pressure controlled (systolic <140 mmHg and diastolic <90 mmHg) at most recent outpatient visit, **by age category**.



RECOMMENDATIONS

- Obtain blood pressure measurements at every patient visit.
- Encourage self-blood pressure monitoring.
- Develop a hypertension registry to identify patients who have uncontrolled hypertension.
- Use a multidisciplinary team approach and work with patients on a hypertension management plan.
- Establish staff competencies for correct blood pressure measurement.
- Give providers regular feedback on their patients' blood pressure control rates.
- Follow an evidence-based hypertension treatment protocol.

LIMITATIONS

- Patients with missing blood pressure values were considered 'Not Controlled'.
- Excluded patients aged >85 years during the calendar year, blood pressure dates outside of reporting calendar year, and systolic (SBP) or diastolic blood pressure (DBP) values outside of acceptable range (SBP <60 mmHg or SBP >240 mmHg and DBP <40 mmHg or DBP >150 mmHg).

*Adults in the PCMH patient population who had ≥1 outpatient visits during 2014 and who were diagnosed with hypertension using ICD-9 code groups 362.11; 401.00-401.99; 402.00-402.99; 403.00-403.99; 404.00-404.99.
**Includes data from all PMCH clinics that submitted patient level data.

Questions?

Call 1-800-332-6148

Or visit www.csimt.gov

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